Agenda Item 86/12

Capacity Planning Progress Report

Purpose of the Report:

- To report on case for change of capacity requirements at Watford General Hospital;
- To note the recommended plans to improve productivity, efficiency and capacity;
- To view proposals in the context of the overall clinical site strategy (SERP); and
- To provide assurance on the work in hand to review affordability and funding arrangements.

The Board is asked to delegate authority to agree the business case for the actions on capacity to the Chairman and Chief Executive.

Report by:

C Pocklington — Chief Operating Officer
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Executive Summary

This paper reports on plans to address the bed capacity issues at Watford General Hospital and briefly summarises the case for change, opportunities to work differently, options for creating additional physical beds and the governance process to ensure that plans are affordable.

Insufficient bed capacity is a challenge that is familiar to all Acute Hospitals in ensuring that the right bed is available for patients at the right time. However, problems on a daily basis can result in a poor patient experience, lower staff morale and inefficient care pathways with patients 'outlying' in ward areas that are not best suited to their needs. This poor experience is then translated into organisational failure to meet key performance targets.

Work completed during 2011-12 to improve bed capacity at Watford Hospital both by working differently and by establishing an additional 18-bedded 'surge' ward has proved essential in maintaining care quality over recent months, particularly given a recent 'step-change' in the volume of admissions to the Watford site. In preparation for 2012-13, an external review of bed requirements across all WHHT sites has been completed by Capita who have acknowledged expertise in this field. This indicates that this year Watford Hospital requires an extra 6 beds at all times and a further 29 beds to cope with activity at peak times.

In response to the capacity pressures, each Division has challenged itself to develop a range of 'Working Differently' proposals which together could release the equivalent of up to 11 beds during 2012-13. However, this will not be sufficient to address either the immediate shortfall in beds that results in medical patients outlying in the cardiac catheter laboratory day beds and surgical cancellations, or the additional requirement at peak times. The working differently proposals are at a varied stage of preparedness to implement and some require design and capital work. Therefore, as an immediate interim

measure, an order has been placed to hire 12 additional beds which will be in place as of July 12, pending a solution that will be more cost effective in the longer-term. This would cover the immediate core shortfall of 6 beds, and would be removed once a longer term solution is in place.

The longer-term solution proposed is the establishment of a 2 x 18 bed, ie 36-bedded facility by December 2012. A unit of 36 beds represents the most flexible, timely and cost efficient way of providing a cohort of bed capacity. The affordability and funding sources are not included in this paper as there is detailed work underway in preparation for the business case economic appraisal. This will include detail on the risks and mitigations of both the construction and operational issues.

Introduction

During 2011, the West Hertfordshire Hospitals NHS Trust Board endorsed a series of measures to improve bed capacity at Watford Hospital, including the establishment of a new 18-bedded ‘surge’ ward for use at peak times. The key aims were to improve bed availability, reduce surgical cancellations and ensure achievement of the care quality indicators for Emergency Care. However, due to a sustained rise in the volume of ambulance arrivals, with a marked increase in admissions from the north of the Trust’s catchment area, almost certainly related to service changes taking place or due to take place at Welwyn Hospital, these aims have only been partially achieved.

Bed capacity therefore remains a key issue and continues to have an adverse impact on patient and staff experiences. Waiting times for elective procedures have increased and performance against the 18-week referral to treatment time target is fragile. Emergency performance also remains a concern, despite the continuous use of the Surge ward. The wider effects of the shortfall in bed capacity on the Trust’s ability to achieve performance criteria, sustain clinical relationships and maintain its reputation represent a significant risk that must be managed.

This document therefore informs the Board of current plans to manage this operational risk, and mitigate the financial cost of acquiring additional bed capacity. The information provided is at a relatively high level, as the detail will be covered in individual Business Cases, and includes:

1. The Case for Change and Capacity Assumptions
2. Opportunities to Work Differently
3. Options for Additional Physical Beds
4. Business Case Development: Affordability, Risk & Governance
5. Recommendations

1. The Case for Change & Capacity Assumptions

1.1 Case for Change

There are several factors underpinning the current capacity issues at Watford Hospital. These were discussed in detail at the March 2012 Trust Board meeting and fall under the following key headings:

- Increasing number of ambulance admissions to Watford Hospital;
- Additional activity from ‘AL’ postcode areas following service changes at Welwyn Hospital
- Rising A&E attendances at Watford Hospital; and
- Changing demographic in West Herts and an aging population.

Whilst work completed during 2011-12 to improve bed capacity at Watford Hospital both by working differently and by establishing an additional 18-bedded ‘surge’ ward has

proved essential in providing care appropriately for the increased number of patients, further changes are still needed to ensure that the Trust can provide the quality of care it aspires to and also deliver its key performance targets, particularly those relating to emergency and elective waiting times.

1.2 Scope of Capacity Review

A review of 5-year bed capacity requirements across all WHHT sites was completed in May 2012 by an external company called CAPITA. The review used activity information from 1 March 2010 to 29 February 2011 as its baseline and then took the following items into consideration in reaching its conclusions:

- The impact of predicted changes to demography and epidemiology
- Elective demand and achievement of waiting list targets
- Commissioning intentions and changes to market share
- Benchmarked clinical performance against similar trusts
- Audit Commission theatre availability and utilisation targets
- Impact of quantified QIPP schemes for 2012-13
- Additional surgery should the vascular bid be successful
- Full-year impact of patient flow from St Albans & Harpenden

It did not take account of the possibility that the above patient flow related to the change at Welwyn Hospital might increase further as further changes take place there.

1.3 Immediate Bed Capacity Requirements

The key finding of this review was that Watford Hospital does not have sufficient beds to accommodate both its medical and surgical patients. A minimum of 6 additional beds are needed at all times (counting the current ‘surge’ ward as constant capacity) and a further 29 additional beds, or ‘bed-equivalent efficiency improvements’ need to be in place to manage times of peak activity during 2012-13. Bed requirements for 2012 -13 are summarised in Table 1 below and the full CAPITA report is available on request:

Table 1: Minimum Bed Capacity Required for 2012 – 13 at Individual Hospital Sites:

	Hemel Hospital	**St Albans Hospital**	**Watford Hospital**				
Bedpool:	Medical	Surgical	Medicine core [1]	Medicine at peak times	Gynaecology	Orthopaedics	Surgery
2011/12 Actual Overnight Beds	50	28	283	301	27	51	80
2012/13 Bed requirement modelled	42	30	307	336	20	51	87
2012/13 Variance	**-8**	**+2**	**+24**	**+35**	**-7**	**0**	**+7**

This capacity model has been challenged and reviewed in great detail and the bed numbers outlined in Table 1 now form the agreed basis of the Trust’s capacity planning for 2012-13. WHHT therefore needs to put in place both additional physical bed capacity and ‘bed-equivalent’ efficiency gains that together will provide sufficient capacity to ensure that patients’ needs can be met.

[1] The new 18-bedded area, implemented in 2011 as a ‘surge’ facility for use at peak time only, has been in constant use over the past five months. According to the modelling, the Trust needs to expect that are part of the ‘core’ bed complement during 2012/13 and will be open throughout the year.

1.4 Link with Clinical Site Strategy ('SERP')

In agreeing appropriate bed capacity plans for 2012-13, it is vital that they are set in the context of longer-term expectations. CAPITA have assessed the 5-year bed requirements for WHHT based on a variety of different planning scenarios and have no expectation that activity at the Trust is likely to reduce such that the bed numbers above would not be needed. Indeed, as noted earlier, the further "downgrading" of Welwyn as an acute hospital is likely to create further upward demand pressure. The establishment of additional capacity at Watford Hospital is also in line with WHHT's longer-term clinical service and site strategy and is not expected to have a detrimental effect on plans for clinical adjacencies over the coming years. Taking the changes required at the Hemel Hempstead site into consideration, having sufficient or even a small surplus of beds at Watford is likely to prove useful in enabling future change across all sites.

2 Opportunities to Work Differently

Building additional beds is not the only means of ensuring that patients' needs will be met as activity increases, particularly as this option brings with it additional challenges in funding and staffing any new facility. There are always opportunities to work differently to further drive efficiency, often in partnership with community care providers. Each Division has considered its plans for driving efficiency further and their proposals are summarised below.

Proposal Outline:				Impact Assessment:	
Title	**Description**	**Potential Timescale**	**Delivery Risk Rating**	**Potential Beds Released**	**Maximum Cumulative Total**
Outpatient Hysteroscopy Service	Hysteroscopy patients seen as outpatients rather than as inpatients.	Jul-12	Amber	0.5	0.5
Weekend Therapy Service	Weekend rota piloted to facilitate discharges from AAU and A&E	Jul-12	Amber	1	1.5
Gynae Elective Activity to SACH	Two additional gynae lists to be set up at SACH for lower anaesthetic risk patients.	Aug-12	Amber	0.5	2
Gynae Enhanced Recovery Nurse	Specialist nurse to assist with recovery of cancer patients.	Aug-12	Green	0.5	2.5
Gynae ERPC Procedures	Transfer non-emergency ERPC procedures to SACH	Aug-12	Amber	0.5	3
Extended Pharmacy Service	3-month pilot to assess the impact of having the dispensary open longer at weekends.	Sep-12	Amber	1	4
Development of Recovery Unit	Create a dedicated recovery area so that biopsy / diagnostic patients do not require an inpatient bed to recover.	Aug-12	Amber	2	6
Medical Division Ambulatory Care Facility	Create a designated clinic facility and waiting area so that patients who do not need an inpatient bed can still receive immediate specialist care and in so doing free up existing bed spaces for use by inpatients.	Sep-12	Green	2	8

Proposal Outline:				Impact Assessment:	
Title	**Description**	**Potential Timescale**	**Delivery Risk Rating**	**Potential Beds Released**	**Maximum Cumulative Total**
Medical Workforce Redesign	Recruit additional Acute Physicians to support the delivery of ambulatory care and other changes to medical working patterns to improve continuity and hence length of stay.	Oct-12	Red	2	10
Relocation of Surgical Admissions	Reconfigure beds so that surgical admissions are reviewed on Level 5 of PMOK, rather than in the AAU and ambulatory care enhanced.	tbc	Amber	1	11

Notes:

- Whilst this paper focuses on adult bed capacity, children's emergency pathways have also been under sustained pressure from increasing activity. The Board therefore need to be aware that a Business Case is currently being developed to establish a Short Stay Paediatric Assessment Unit to alleviate capacity issues within the Children's Emergency Department.
- Impact and timescales shown are only indicative at this stage and whilst every effort has been made to assess the viability of schemes prior to their inclusion in this document, some of the 'Working Differently' schemes outlined above may not progress past the Business Case stage should detailed work show that they are not practically or financially possible.

Working differently will deliver results and the more work that can commence to improve efficiency during 2012-13, the better the Trust position will be going through the next winter and into 2013-14. However, efficiency improvements alone cannot resolve the immediate capacity issues, nor can they create sufficient capacity to bridge the existing gap. Additional physical beds will therefore be required.

3 Options for Additional Physical Beds

Three key schemes have been identified to create additional physical beds during this financial year. They are available to Board members in the table included as Appendix I on the shared drive. This table outlines each scheme, along with its associated benefits and issues or dependencies and a delivery risk rating. With the immediate requirement to release the pressure on the cardiac catheter laboratory day beds, plans for mobile units totalling12 beds are already in progress and the units will be in place by July 2012. In the longer term, the other plans for 2012-13 are:

- Decant administrative staff and convert / create 5 bed spaces alongside Elizabeth Ward. This could be in place as of September 12
- Lease a 30-36 bed ward. This could be in place by December 12 at which point the 12-bed mobile units would be released.

4 Business Case Development

4.1 Affordability & Governance Process

Agreeing the most affordable option will form part of a Business Case to review both the costs of putting any buildings and connectivity in place and also the operational staffing / running costs. Potential options to provide less physical beds will also be reviewed with associated risks. Given the need for speed, the proposed approval route for this Business Case is via Chairman's action, using his delegated authority. Similarly, cost estimates for the Working Differently proposals are at various stages of development, and will need appropriate scrutiny dependent on the level of investment proposed.

Key to the affordability of the approach set out in this document is ensuring that the additional activity that it assumes is in line with PCT expectations. Work is in progress to outline the additional activity anticipated and to confirm the additional income and costs associated with this. There is a national directive that additional emergency activity should normally only be funded at a 30% marginal rate, whereas WHHT has experienced a clear and abnormal step-change in activity due to service changes at other acute providers and local population growth. A final position statement regarding additional activity and income will need to be agreed with the PCT prior to finalising the Business Case for the 36 additional beds. PCT transformation funding will also be sought to support 'Working Differently' changes wherever possible. To date the PCT have been positive in expressing their support for solutions to the additional activity pressures and with providing financial support for the 12-temporary beds that will be in place as of July 12.

4.2 Risk & Governance

Key risks and mitigations for the physical solutions and for the 'do nothing' option have already been assessed and a summary is included as Appendix II, which is again available to members on the shared drive. In order to ensure appropriate governance of the implementation process, the following process is proposed:

- The Trust will operate a 'star chamber panel' to review all Working Differently' plans with the project leads and understand the milestones for implementation and any reason why they are not being met. This will be via the Getting Better processes, as the schemes are all about delivery of efficiencies and it is worth noting that the headline schemes have been discussed at the Clinical Strategy Group with good attendance and representation across all divisions.
- There will be close control of the capital costs of any project via the Capital Programme Board.
- The Trust is in close liaison with the PCT about funding mechanisms for either a rented or built facility and will need to find ways of managing any gap in funding.
- Delivery of this work programme will be overseen by a project board, which will be defined as part of the business case
- An overall programme management structure based on PRINCE2 principles will be established, with clear leadership arrangements and each Division taking responsibility for the changes that they have proposed.

5 Recommendations

The Trust Board is asked to:

- Support the principles for additional capacity requirements outlined in this document and agree the actions underway in both the short and medium term; and
- Support the continued financial and affordability analysis of all options and pursuit of funding sources
- Agree that the final / full business case should be approved by Chairman's action, subject to it demonstrating affordability.
- Recommend any additional actions required.

Appendix I: Options for Additional Physical Beds

Proposal Outline:				**Impact Assessment:**		
Description	**Benefits**	**Issues & Dependencies**	**Delivery Risk Rating**	**Beds Created**	**Fit with Strategic Site Plan**	**Funding Stream Options**
Provide 12 immediate (temporary) beds at Watford. Will be in place as of July 12.	• Addresses the immediate shortfall in beds. • Will assist with reducing cardiology and surgical cancellations, but will not entirely solve the problem.	• Staffing 2 x 6-bedded units will be expensive, but this is the only option that can be instituted quickly enough.	Green An order for these beds has been placed.	+12	Temporary measure, so would have limited impact on longer-term plans. Would also be sited in such a way that it does not interfere with any other plans for additional capacity during 2012-13.	Transformation Funds from PCT
Create 5 extra female beds alongside Elizabeth ward Could be in place as of September 12.	• Additional capacity can be created at a lower cost than leasing or building additional beds.	• Relies on the transfer of administrative staff from a clinical area to Sycamore House.	Amber	+5	This would not have an adverse impact on any other plans at this stage.	Funding from capital programme reprioritisation
Lease an 30-36 bedded additional ward at Watford. Could be in place as of December 12.	• Significant improvement to bed capacity. • A 2-storey facility can be created adjacent to AAU.	• Most expensive option and the impact on the Trust's long-term financial model needs to be assessed.	Amber	+30 / 36	As a temporary building, it will not have an adverse impact on site plans.	Transformation funds / Revenue

Appendix II: Assessment of Risks

Organisational Risks of 'Do Nothing' Option

Risk	Risk Assessment:			Mitigation Strategy
	Likelihood	Impact	Score	
There is an adverse impact on patient care and experience and the Trust fails to achieve its care quality targets.	5	5	25	Continuous close monitoring of bed availability and escalation measures used to ensure safety of hospital care.
Surgical and cardiological procedures routinely cancelled and failure to achieve 18-week waiting time target.	5	5	25	Close monitoring of elective lists and use of private sector if required.
Adverse impact on staff and staff morale.	4	4	16	Review arrangements and reinforce need for support of staff in areas most affected.
Watford hospital is vulnerable to greater adverse impact on care should there be an activity increase, infectious outbreak or capacity in community services become more limited.	4	4	16	Continuous close monitoring of bed availability and escalation measures used to ensure safety of hospital care.

Organisational Risks of Proceeding with Proposals Above

Risk	Risk Assessment:			Mitigation Strategy
	Likelihood	Impact	Score	
Proposals are still a work in progress and costs / viability may well change, given speed of planning and delivery.	4	4	16	Robust review of Business Cases and strong project management arrangements for all changes.
Length of stay increases as a result of having additional beds and outlying into surgical and cardiological areas continues.	3	5	15	Length of stay is one of a suite of indicators routinely measured and this will continue. However, discharging patients early as a result of operational pressures is not desirable either.
Risks arising from capital / construction element of establishment of additional beds.	3	4	12	Close liaison and project management with both contractors and operational teams. Review of 'lessons learnt' from previous implementation.
Potential adverse impact on WHHT's financial position and long-term financial model.	3	4	12	Robust review of Business Cases and strong projec management arrangements for all changes.
More beds at Watford will mean less incentive to resolve issues regarding patients with Delayed Transfers of Care on Churchill ward at Hemel Hempstead Hospital.	4	3	12	From a patient pathway perspective, this issue does need to be resolved as a matter of urgency. However, releasing beds at Churchill ward does not mean a commensurate reduction in the beds needed at Watford hospital as acute patients need to be cared for on the Watford site.
Additional capacity created is not enough to meet demand. Also, whilst additional beds will benefit both Medicine and Surgery as soon as they are instituted, the full benefit will not be felt by the surgical division until such point as they have the number of beds recommended by CAPITA routinely available to them.	1	4	4	The CAPITA review of beds needed acts as mitigation to this risk. . Reconfiguring of the bed base at WGH across Divisions will need to be agreed as part of creating additional beds and working differently proposals prioritised in such a way as to ensure equitable bed distribution.
Additional capacity is not needed to meet demand.	1	1	2	Extra capacity at Watford would provide opportunities to review configuration of beds across sites and reduce number of WHHT beds at Hemel. Also, all recently established additional capacity is leased, with the lease on the existing Red Suite expiring in Dec 14.

Capital Risks Associated with 36-Bedded Facility & Mitigations:

The following have been identified as the key risks to the Trust from the 12/13 Capacity Programme [risk scores are Likelihood x Impact]:

Ref	Risk Description	Mitigations	Cost £k		
			Best Case	Most Likely	Worst Case
1	Unknown ground conditions resulting in need to increase foundation depth and increase costs over baseline 4x3 = 12	Use of Campus ground condition surveys to analyse. QS estimate based on piled foundations included as starting point	50	150	250
2	Timeline precludes full planning of clinical service and required equipment. Costs increase as necessary to fulfil clinical requirement 4x3=12	Learning from last years exercise in generating cost allowances for equipment.	50	100	250
3	Planning application rejected because of local objections to further increase in activity without road infrastructure 2 x 4 = 8	Working with WBC to prepare an application. Preparing traffic assessments. £7m road building fund.	250	1,000	7,000
4	Requested planning application requires content unusual for the scale of project 3 x 4 = 12	Working with WBC to evaluate the content to satisfy due process	50	100	500
5	Trust SFI's/ Procurement processes unable/ too complex to keep up with required/ desired speed of delivery. 5 x 4 = 20	Waivers to be requested where considered necessary at Exec Level.	10	50	1,000
6	Internal resource allocation insufficient, resulting in poor decision making 4 x 4 = 16	Clinical divisions to have identified leads who have guaranteed windows of availability for Project Team	0	100	500
7	Internal resource allocation insufficient, resulting in record keeping being sacrificed to speed 4 x 3 = 12	Trust internal Project Management costs allowed in cost plans.	0	20	50